BUREAU OF MOTOR VEHICLE SERVICES
301 C Street, N.W.
Washington, D.C. 20001
DIABETIC EYE REPORT

APPLICANT'S NAME _____ PERMIT NO. _____

ADDRESS _____

VISION WITHOUT GLASSES	RIGHT EYE	20/_____	* VISION WITH GLASSES	RIGHT EYE	20/_____
	LEFT EYE	20/_____		LEFT EYE	20/_____
	BOTH EYES	20/_____		BOTH EYES	20/_____

1*If vision is improved to meet Motor Vehicle standards with glasses but glasses are not prescribed o recommended for driving, state reason: _____

_____

FIELD OF VISION: To be measured in the horizontal meridian by confrontation or perimetry, both eyes open.

TOTAL DEGREES_____

If applicant is under treatment for glaucoma and/or cataracts, please advise of treatment and any restrictions

_____

_____

If there are any limitations of field, ocular movement or ocular disease which would limit applicant's ability to drive an automobile safely, please indicate: _____

_____

_____ _____

DATE OF EXAMINATION
(Examination must have been within 90 days of date presented to Motor Vehicle Services)

OPHTHALMOLOGIST OR OPTOMETRIST

_____

ADDRESS

_____

TELEPHONE NUMBER

_____

NOTICE TO APPLICANT

When an Optometrist executes this report and he finds an eye disease which may be associated with diabetes, he will refer you to an Ophthalmologist for further examination and completion of the form below:

1. Diagnosis _____ 2. Prognosis _____

3. Is medical treatment indicated at this time? _____

_____

OPHTHALMOLOGIST

_____ _____

DATE OF EXAMINATION

ADDRESS

_____

TELEPHONE NUMBER